MINNESOTA LIFE

ENROLLMENT APPLICATION FOR
FAIRFAX COUNTY GOVERNMENT
GROUP POLICY #: 29267

SECTION A. EMPLOYEE INFORMATION

EIN or SOCIAL SECURITY NUMBER	EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)		
STREET ADDRESS	CITY	STATE	ZIP CODE
DATE OF BIRTH (MO./DAY/YR.)	EMPLOYMENT DATE (MO./DAY/YR.)	EMPLOYEE'S ANNUAL SALARY	

SECTION B. REASON FOR REQUESTING (select one)

☐ I am a new employee or newly eligible for benefits. I am requesting optional life insurance coverage or waiving coverage as listed in Section C below. I understand the following:

- **1x or 2x optional coverage is guaranteed issue,** if applying within the first 60 days of employment.
- **3x or 4x optional coverage requires evidence of insurability.** (Contact DHR or download the form from the benefits page on the INFOWEB.) **Evidence of Insurability must be approved before coverage is effective. The form will be sent to you directly from Minnesota Life**.

☐ I want to **increase my optional or dependent** coverage. Indicate your **NEW** election in Section C below. I understand the following:

- I may add a newly eligible spouse or newly eligible dependent children within 60 days of initial eligibility without providing evidence of insurability. I must request the change within 60 days of the qualifying event and provide a copy of my marriage certificate, birth certificate, hospital proof-of-birth letter or legal adoption papers for guaranteed issue coverage.
- I am requesting optional or dependent coverage past my initial 60 days eligibility period. I must request during the annual open enrollment period. Evidence of Insurability will be required **for each person** for whom I am requesting coverage. An Evidence of Insurability form will be sent to me from MINNESOTA LIFE. I must return the form(s) and be approved by Minnesota Life before coverage can go into effect.

☐ I want to **decrease my optional or dependent** coverage. Indicate your **NEW** election in Section C below. Optional coverage may not be decreased outside of open enrollment unless it will result in at least **$50,000 of optional coverage remaining.**

SECTION C. ELECTION OF INSURANCE AMOUNT

Basic Coverage: Paid for in full by the County.

☒ **1x annual salary**

Additional Optional Employee Coverage: Optional Coverage – paid for in full by the Employee. **Please select one:**

☐ 1x annual salary ☐ 2x annual salary ☐ 3x annual salary ☐ 4x annual salary

☐ Waive or Cancel. **I DO NOT** wish to enroll for optional employee coverage or I am requesting cancellation of this coverage. I understand that once coverage is waived or cancelled, I will be required to furnish evidence of insurability if I wish to become insured at a later date.

Dependent Coverage Please select one**:**

☐ $6,250 spouse/$2,500 children (child: age 10 days to 23 years); or ☐ $12,500 spouse/$6,250 children (child: age 10 days to 23 years)

☐ Waive or Cancel. **I DO NOT** wish to enroll my eligible dependents for life insurance coverage or I am requesting cancellation of this coverage. I understand that once coverage is waived or cancelled, I will be required to furnish evidence of insurability for eligible dependents if I wish to insure them at a later date.

SECTION D. PAYROLL DEDUCTION AUTHORIZATION

If I have elected optional and/or dependent coverage, I hereby authorize FAIRFAX COUNTY to deduct from my compensation the amount necessary to provide the insurance amount(s) indicated above.

SIGNATURE OF EMPLOYEE	DATE SIGNED

Return form to: Department Human Resources 12000 Government Ctr. Pkwy., Suite 270, Fairfax, VA 22035 or FAX it to 703-802-8795

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